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February 28, 2008

Teresa Carpenter
Preferred Community Homes Courtyard
615 Second Avenue West
Wendell, Idaho 83355

Provider #13G057

Dear Ms. Carpenter:

On **February 14, 2008**, a Complaint Investigation was conducted at Preferred Community Homes Courtyard. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003416

Allegation #1: Individuals' incontinence briefs are not changed frequently.

Findings: An on-site investigation was conducted from 2/13/08 - 2/14/08. During that time observations, record review, and staff interviews were conducted with the following results:

During observations on 2/13/08 from 4:55 - 5:30 p.m. and 6:20 - 7:10 p.m., and on 2/14/08 from 12:05 - 12:45 p.m., individuals were noted to be toileted on a consistent basis, and no individuals were noted to be incontinent. Additionally, during an observation on 2/14/08 from 12:05 - 12:45 p.m., individuals' toileting records were reviewed and found to contain regular documentation which was consistent with observed toileting practices. Three sample individuals' medical records were reviewed and showed no indication of infrequent toileting as evidenced by issues such as rash or skin break down.

On 2/13/08 and 2/14/08, nine direct care staff and two former staff were interviewed with the following results:

All direct care staff and both former staff identified those individuals residing in the home who required the use of incontinence briefs and toileting schedules. All direct care staff and both former staff stated individuals were to be toileted every two hours and as needed as identified by incontinence accidents. All direct care staff and one former staff stated they had no knowledge of individuals being left in soiled incontinence briefs or staff failing to toilet individuals as needed or required. One former staff stated she was aware of individuals sometimes not being changed but was only able to give one specific example where an individual arrived home on the school bus with a wet incontinence brief.

Additionally, staff at two schools were interviewed on 2/14/08 and stated they were not aware of individuals not being toileted or changed on a regular or as needed basis.

On 2/14/08, an interview was conducted with the Administrator, QMRP (Qualified Mental Retardation Professional), and LPN (Licensed Practical Nurse), all of whom stated they were unaware of issues or concerns of individuals not being toileted or changed on a regular or as needed basis.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Staff slap individuals' faces. One individual had their arm twisted behind their back. One individual is made to sit in the tub as a form of punishment.

Findings: An on-site investigation was conducted from 2/13/08 - 2/14/08. During that time observations, record review, and staff interviews were conducted with the following results:

During observations on 2/13/08 from 4:55 - 5:30 p.m. and 6:20 - 7:10 p.m., and on 2/14/08 from 12:05 - 12:45 p.m., no incidents of abuse were observed. A review of the facility's Accident/Incident reports and investigations from 11/1/07 to 2/13/08 did not contain evidence or allegations of abuse.

On 2/13/08 and 2/14/08, nine direct care staff and two former staff were interviewed with the following results:

All current staff and one former staff stated they were unaware of individuals' faces being slapped or an individual having their arm twisted behind their back. One former staff stated she witnessed a staff member "slap" an individual on the leg to get their attention, but stated the incident did not leave a mark and was unable to state if the action was a slap or a tap. A second former staff stated she had witnessed staff slapping individuals' faces but stated she did not report the incidents. The former staff stated she had heard another staff member bent an individual's arm behind their back, but did not witness the incident.

Eight of the current staff and one former staff stated they were unaware of an individual being made to sit in the bathtub as a form of punishment. One current staff stated she had heard an individual was placed in the bathtub one time during a behavior and it calmed him down. The staff stated she did not witness the incident and had not seen anyone place an individual in the bathtub. One former staff stated she was aware of a staff placing an individual in the bathtub during a maladaptive behavior but stated she did not report the incident.

Additionally, staff at two schools were interviewed and stated they had no knowledge of individuals' faces being slapped and had not seen marks or injuries that would cause concern of abuse.

A review of the facility's Accident/Injury reports, investigations, and three sample individuals' medical files did not include documentation of injuries consistent with the allegations.

On 2/14/08, an interview was conducted with the Administrator, the QMRP (Qualified Mental Retardation Professional), and the LPN (Licensed Practical Nurse), all of whom stated they were not aware of any incidents where staff slapped individuals' faces or of an individual having their arm twisted behind their back. The Administrator stated she had been called to the facility, date unknown, because an individual had been upset. She went to the facility and found the individual sitting in the bathtub. When the Administrator asked the individual why he was sitting in the bathtub, the individual stated he wanted to sleep there. The individual was clothed and there was no water in the bathtub. The Administrator asked the individual to get out of the bathtub and he complied. The Administrator stated the individual was not placed in the bathtub as punishment but had climbed in the bathtub on his own when he was agitated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/mlw